Shaping and reshaping the work organisation: including or excluding low skilled labour? The case of the nurse assistant in Germany, France and the United Kingdom[1]

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Introduction

In socioeconomic research much attention has been paid to the interdependencies between the division of labour within the firm and the vocational training system as well as other characteristics of the socioeconomic context that affect the free choice of the firm's management in organizing work. This has contributed to a profound knowledge of the specifities of national 'models', on the institutional complementarities e.g. between labour market institutions and the vocational training system, which in turn may explain a certain stability over time of institutions and of the labour division within firms. The focus, however, has often been on medium and high skilled labour and the mobility between these skill levels, and less on low skilled labour. One might argue that, by definition, low-skilled or 'unskilled' labour has weaker ties with the vocational training system and therefore the well explored national differences between the vocational training systems and occupational structures are not paralleled by comparable differences concerning low skilled work. Our paper, therefore, seeks to shed light on the lower segments of the skill hierarchy and explore whether it simply 'mirrors' the structures and tendencies observed for the higher skill levels or whether the developments in this segment are characterized by influences from different institutions and by a different pace of change. The importance of the issue of low skilled work becomes evident if we look at the quantitative trends in educational attainment: Low skilled people, i.e. persons with less than upper secondary education, are not a residual group but still make up between 17% (Germany) and 35% (France, UK) of the population in the age group between 25 and 64 (OECD 2005). As job prospects for them, both in qualitative terms (decreasing wages and mobility), and quantitative terms (high unemployment rates) have worsened since the 1980s there is a rising political concern about inequality of labour market participation among low and high skill groups, and mobility out of low wage work. Our paper focuses on the low skilled part of the nursing staff within hospitals and mainly on the nurse assistant position. As these are predominantly female jobs, it allows also to go further as most of the international comparisons have focused on male and industrial sectors.

The hospital industry could be characterised on the one hand as under "industrial constraints" (just in time, 24 hours opening, and on the other hand as a service activity with, in departments, a high degree of patient oriented activities. Very similar pressure are exerted on hospitals in the three countries (UK, G and F): budget constraints and a trend to "quasi market" regulations (cf. Bartlett/LeGrand 1993); changes in the competitive structure linked with the increasing importance of private hospitals; a new demand for care arising from the ageing population and more complex diseases; new rules to control for the quality of care. Despite these similarities between the external demands and constraints, the organisation of care work and the division of labour remains very different between the countries.

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Section 1 presents a brief historical perspective of the nurse assistant in the three countries and the major contrast regarding the level and trends of employment. Section 2 analyses the training profiles and access to training. Section 3 describes the tasks performed and draws the job profile of a NA. Section 4 discusses the wage levels and structure and section 5 patterns of mobility.

Box 1: methodology
The paper is a part of wider research undertaken in five countries for the Russell Sage Foundation on "Low Wage Work in Europe". The analysis is based, on the one hand, on national data at the industry level, and on the other hand on case studies in hospitals. In each country, 6 to 8 case studies have been completed, with interviews with managers in the hospitals, employee representatives (unions, works council), and workers performing the same kind of tasks (cleaning the patient rooms, providing elementary nursing) in medical departments. Interviews focussed on the wage structure and levels, mobility patterns, job content, position in the division of labour, and working conditions. Depending of the division of labour, the interviewees were either cleaners, house keepers, nurse assistants or equivalent, or nurses.

1. A short history and some major trends

Looking first at the history of labour division in hospitals we do not seek, at first hand, to draw on path-dependency explanations but, more in line with the 'societal effect' school, regard this as a method "in order better to identify those dimensions of our analysis most relevant to an understanding of the processes at work today in the 'construction of the actors'" (Maurice/Sorge 2000: 21). As in other industries, a category of low-skilled workers distinct from other employee groups emerged as a result of the processes of formalisation and institutionalisation of vocational training and occupational roles for intermediary skill levels. During the 20th century nationally recognised diplomas for nurses were created and in addition to that, in some countries like France and Great Britain, nurses awarded with a national diploma were granted the exclusive right to practice as nurse. Employees without a nurse diploma, however, did not disappear from the hospital; even today they make up a considerable part of nursing staff in hospitals, although the proportion varies strongly from country to country which we discuss later. However, the differences do not only concern the quantity of staff below the level of a nurse; as Abel-Smith (1960) argues, much of the history of the division of labour in nursing was a struggle over the 'second portal', namely, a skilled grade assisting the skilled nurses. In all three countries in our sample such a 'second portal' was introduced during the 1950/60's, but this is where the similarities end.

To summarise, only in France has the legal status of the 'semi-skilled' position been maintained and enhanced *and* remained an occupation that hospitals extensively recruit. In the other two countries, different developments have contributed to an erosion of this officially recognised position; in Germany, although there still exists a specific legislation that regulates the status and the vocational training of nursing assistants, this legislation has lost its importance for labour division in hospitals due to the strong decrease of the number of nursing assistants employed by hospitals since the 1970s. In the UK, the position of a semi-skilled assistant nurse ('state enrolled nurse') was abolished in the late 1980s which, unlike in Germany, led to the growth of a 'third portal', i.e. nursing auxiliaries without any compulsory formal training required.

These dynamics were already at work when the hospital sector was increasingly faced with the changes and challenges mentioned above (financial constraints, new demand for care...) and prepared the ground for quite different responses to these 'external' changes, as the employment trends in nursing during the last 15 years reveal (cf. Table 1).

Table 1. Employment trends in nursing, 1992-2005

UK	***1992***	***1999***	***2001***	***2005***
Nurse	458,000		445,000	485,000
Nursing ass.	194,000		229,000	199,000
Ratio nurse / nursing ass.	2.36		1.94	2.44
France	***1992***	***1996***	***2000***	***2002***
Nurse	199,000	203,000	228,384	228,264
Nursing ass.	175,000	186,900	193,902	210,129
Ratio nurse / nursing ass.	1.14	1.09	1.17	1.08
Germany		***1997***	***2000***	***2004***
Nurse		377,000	381,000	373,000
Nursing ass.		43,000	38,000	32,000
Ration nurse / nursing ass.		8.77	10.03	11.66

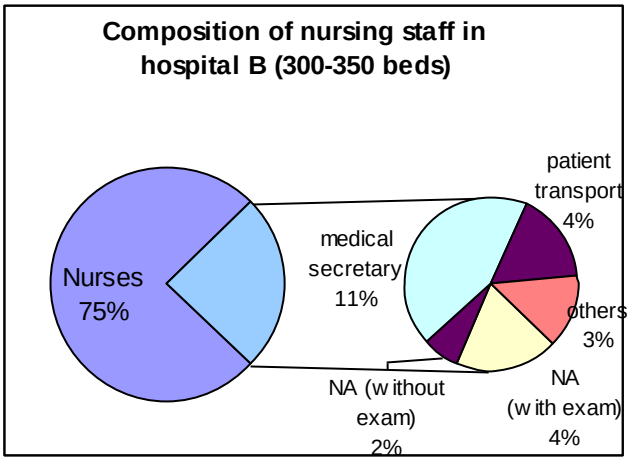
Sources:
UK: Labour Force Survey, headcounts
GER: Statistisches Bundesamt, Gesundheitspersonalrechnung; figures relate to full time equivalents
FR: Dress, statistique annuelle des établissements de santé, head counts

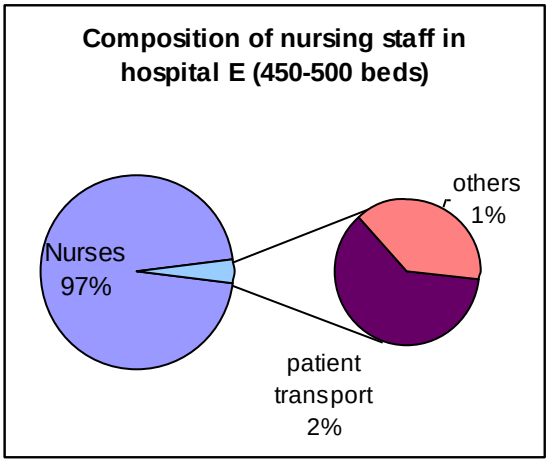
In Germany, the number of nurses has decreased slightly (-1% FTE between 1997 and 2004), whereas the number of nursing assistants has dramatically declined over the same period (-27% FTE, -42% (head count) from 1991). In the UK, from 1999 to 2005, the number of nurses has remained stable (LSF) but has increased in England (+18% -1999 to 2003-, DH statistical bulletin). Nurse assistants and 'health care assistants' have strongly increased between 1999 and 2005 (+28%, LFS, +19% England). This is accompanied by a decreasing share of part time, for the qualified nurses (44% to 38%) as well as for the nursing assistants (53% to 46%). In France, from 1996 to 2002, both the number of nurses and nursing assistants have considerably increased (+12%). The part time ratios are lower than in the UK, but have increased as well (from 20 to 24% nurses, 15% to 21% for NA).

As a result the ratio of nurses to nursing assistants varies considerably between the countries: A ratio of more than 10 nurses per nursing assistant for Germany (and increasing), about 1.1 for France (remaining stable) and about 2.1 for the UK (remaining relatively stable, although with more variation than in France). The graph below documents some cases from our case study sample which show a real diversity of hospitals policies, but within clear national patterns.

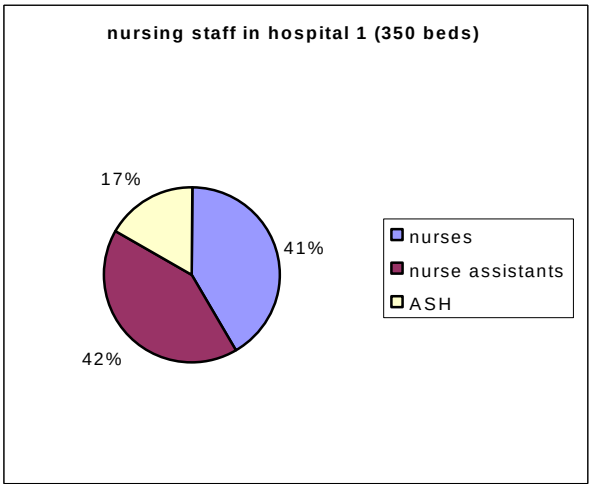
Graph 1: Composition of nursing staff in ‚extreme' cases in sample: (% of emp. per group)

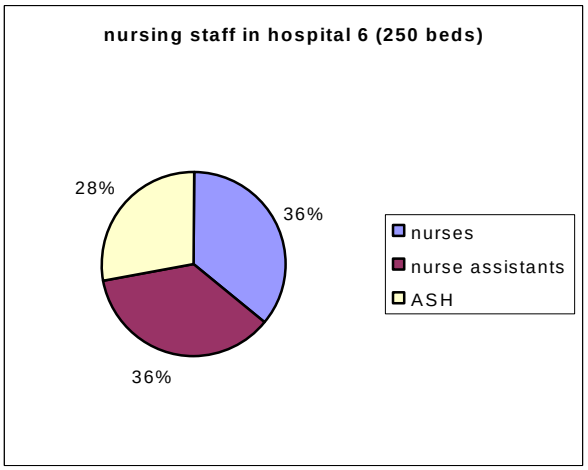
Germany



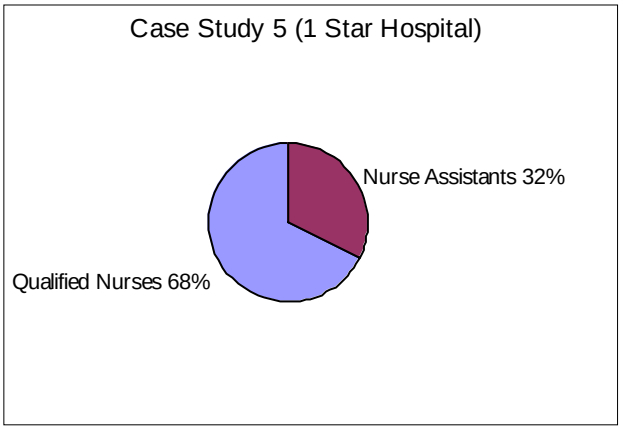


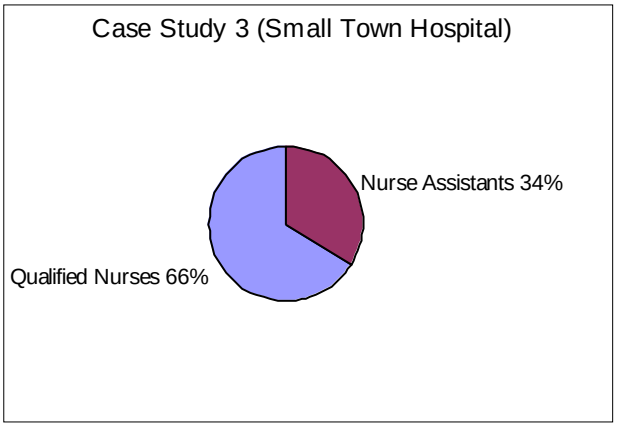
France (public –1- and private –6- hospitals)





UK





To summarise, whereas the composition of nursing staff within French hospitals shows a certain continuity, the employment of nursing assistants in the two other countries has been less stable and was subject to important changes since the 1970s: a net decline occurred in Germany, whereas in the UK nursing assistants, albeit mostly nursing assistants without any formal training, remain an important share of the nursing staff in hospitals and have recently even become more numerous.

What are the factors that might contribute to explaining these different outcomes (and further changes in the future)? On the one hand, the developments in Germany and the UK display differences in cost containment strategies in the two countries, that are also at work in other industries and are well entrenched in the overall institutional setting: In Germany cost containment strategies have traditionally focused on a containment or even reduction of staffing levels among nurses, which in turn resulted in high functional flexibility requirements for nurses and is currently one argument put forward by nurse managers why they abstain from recruiting less flexible nursing assistants.[2] This strategy of cost containment has continued to play a role in the recent changes, as the figures show. In the UK by contrast, the tightening of Treasury rules on expenditure during the 1980s led hospital managers increasingly to look for opportunities to dilute the skills of nursing work, using less expensive nursing assistants without any formal training to carry out tasks traditionally undertaken by qualified and/or enrolled nurses (Dingwall et al. 1988: 225). This strategy was actively promoted by public interventions in the early 1990s, when a new grade of unqualified nurse ('Health care assistant') was introduced in 1991, and hospital managers initially had the freedom to apply local pay structures to this new category outside of the national collective bargaining agreement. Various studies showed that hospitals used the new post as a means of cutting labour costs through setting lower terms and conditions and whittling down the skill-mix ratio between qualified and unqualified nursing staff (Lloyd and Seifert 1995, Grimshaw 1999, Thornley 1996). In both countries public interventions directed towards cost containment have played an important role, and have been quite different in their nature: In Germany, the governance by 'staff reference figures' seems to have discouraged cost cutting strategies based on wage differences, whereas in the UK, the introduction of a new occupation was explicitly aimed at exploiting wage differences.

However, the strategies chosen by hospital management do not only depend on public incentives concerning cost containment strategies but on a wider set of institutions that limit the scope of choice for managers. Among these, the vocational training system and the system of wage setting play an important role and will be explored in the next sections.

[2] This strategy dates back to the seventies, when the statutory health insurance introduced staff reference figures ("Personalanhaltszahlen"), i.e. standard values for the number of employees per bed day, in budget negotiations with the hospitals, as a means of containing job expansion and therefore cost expansion. Staffing increases as a result of service expansion therefore occurred only belatedly and remained significantly below the increase in British nursing staff per bed day (Rothgang 1994: 358ff).

2. Training profiles

A possible reason for the wide differences in the composition of staff is the different qualifications and skills profiles as defined by the national vocational training systems.

In *Germany*, the qualification of nurses is regulated by federal law. Between 1985 and 2003 the same law also regulated the qualification of nursing assistant, but in 2004 the responsibility for the vocational education of nursing assistants was passed to the federal states. So far, 8 out of 16 federal states have adopted their own laws regulating the qualification of nursing assistants. The diploma of nurse and of nursing assistant can be acquired in specific vocational schools that are usually run by one ore several hospitals.

- For nursing assistants the basic requirement granting access to the vocational schools for nursing assistants is a 'Hauptschulabschluss' (=after 9 years of education) which is equivalent to Isced 2. The laws at federal state level entail minimum requirements for the duration and structure of the training: The training spans one year (full time); depending on the federal state the training has to encompass 500-700 hours of classes/tuition and 900-1100 hours of training on the job.
- For nurses, the basic requirement is the 'Mittlere Reife' (=after 10 years of general education), which is equivalent to Isced 2. Alternatively, the nursing assistant diploma also opens access to vocational education as a nurse. The training spans 3 years (full time, or 5 years part-time), with training periods within hospitals. The nurse is regarded as a student in secondary education, and the 3 years are similar to the Isced 3 level. The national law requires a minimum of 4600 hours of training, of which 2100 hours of classes/tuition and 2500 hours of training on the job.

In *France* the qualification of NA and Nurse is delivered by the ministry of health, and is acquired in specific vocational schools, linked with hospitals. It could be public schools (public hospitals, funded by the budget of the hospital) and/or private (mainly non for profit schools, linked to non profit hospitals, such as the Red Cross organization). In both cases, the number of places is regulated by the public authority. The selection process is based on the requirement of basic education level and/or a specific exam.

- For nurses the basic requirement is baccalaureat level (Isced 4, 12 years of education). The duration of studies is 3 years, with training periods within hospitals. The nurse is regarded as a student in tertiary education, and the 3 years is similar to a bachelor degree. Most of the nurses enter nursing school soon after the baccalauréat, some of them after a first year of medical studies where they failed (due to numerus clausus).
- For nursing assistants the basic requirement is a BEP « carrières sanitaires et sociales » (Isced 3, 2 years of vocational full time education after 9 years of general education). If you have this, or a higher degree, the entry selection process is based only on an oral discussion with a jury. If not, there is a class room exam in order to assess your level of education. 25 to 30% of the trainees enter directly from BEP studies. The majority are, however, older women, with previous work experience, often previously unemployed. In some hospitals, unqualified NAs are still employed (roughly less than 5%).

In the *UK* training of nurses was changed in 1988 as a result of a new approach called 'Project 2000'. Prior to this, nurses trained a teaching hospital or in a School of Nursing on the physical site of the hospital. Now training for nurses is in a Higher Educational Environment and student nurses are not on the hospital payroll.

- For nurses, entry requirements were changed by government recently as a strategy to counter shortages in nursing. The government proposed a system of 'widening participation' to encourage more people to enter training who do not have the formal schooling qualifications (five GCSEs for diploma and two 'A' levels for degree courses).

New access routes include having National Vocational Qualifications in Care, accredited prior experiential learning in a relevant field and new access routes run by Institutes of Further Education. Nurse training takes place within a university setting, and nurses are encouraged to study to diploma (240 credits) or degree level (360 credits) (Wales and Northern Ireland require graduate training only). The former lasts three years and the latter three to four years. At the end of the course nurses register with the Nursing and Midwifery Council (established in 2002) and are legally allowed to practice as a nurse in the UK.

- There are no formal educational qualification requirements for recruitment to a nurse assistant position in the UK. However, hospitals' recruitment criteria may specify 'desirable' qualities such as 'GCSE standard' of maths and English, good communication skills or previous experience in a care environment, which may include the care of one's own family. All hospitals are required to offer training (National Vocational Qualifications, usually up to level 3) so as to satisfy the entry requirements for assistant nurses to move into nurse training. It is increasingly expected that NAs, once recruited, will qualify up to at least NVQ2 standard. In addition, hospitals typically provide induction training and mandatory training on topics such as moving and handling, and hygiene.

3. Tasks and division of labour

In all countries, to understand the position of the NA, it is necessary to place the role in the context of the upper and lower categories (the nurse and the room cleaners or others). We must also take into account the role of trainees.

In the 3 countries, the nurse profile is highly regulated. The borderline with the doctors is defined by national regulations. In the UK and in France, the span of medical procedures that a nurse is allowed to perform is higher than in Germany. Partly due to the relationships with the doctor's positions and to the level of qualification, the French and British nurse is more and more a technician of medical procedures, and will delegate more and more the "dirty work" (elementary nursing) to the NA and other HCA. This does not occur on a broad scale in Germany where, on the one hand, the doctors usually do not delegate medical tasks to the nurse and, on the other hand, the nurse will perform some tasks which are usually done by a NA in UK or France. According to a member of the nurses' professional association and to some of the nurse managers interviewed, the biggest obstacles to a stronger delegation of medical tasks is the refusal of doctors to delegate, not only the tasks but also the necessary resources, i.e. additional nursing staff. Without the additional resources nurses are not willing to take on additional responsibility, given the chronic understaffing. Obviously the traditionally low staffing levels among nursing staff contribute to the conservation of the traditional labour division which in turn also 'freezes' the labour division between nurses and nursing assistants.

In France, the NA is under the supervision of the nurse, who is allowed to delegate some tasks (on her own responsibility) to the NA (including some personal physical care: taking blood samples, taking to the toilet alone). In the UK the NA is also under supervision of the qualified nurse. As well as personal physical care of the patient the NA may also take observations (temperature, pulse, blood pressure) but must report anything unusual to the qualified nurse who will take responsibility for deciding what action to take. More highly qualified NAs may also be trained to carry out routine procedures such as taking blood samples. Legally, the giving out of drugs must be done by a qualified nurse.

Obviously, we found in our case studies differences between the official division of tasks and the actual one. It could differ among hospitals, but also among wards and shift organizations. For example, in France, the NA will work more frequently in pairs with the nurse during the afternoon or night shifts, sharing the medical care, than in the morning shift when the nurse is working with

the doctors. As a result, the NA work content could be defined in the negative: a NA is doing what is not defined as a nurse's specific task.

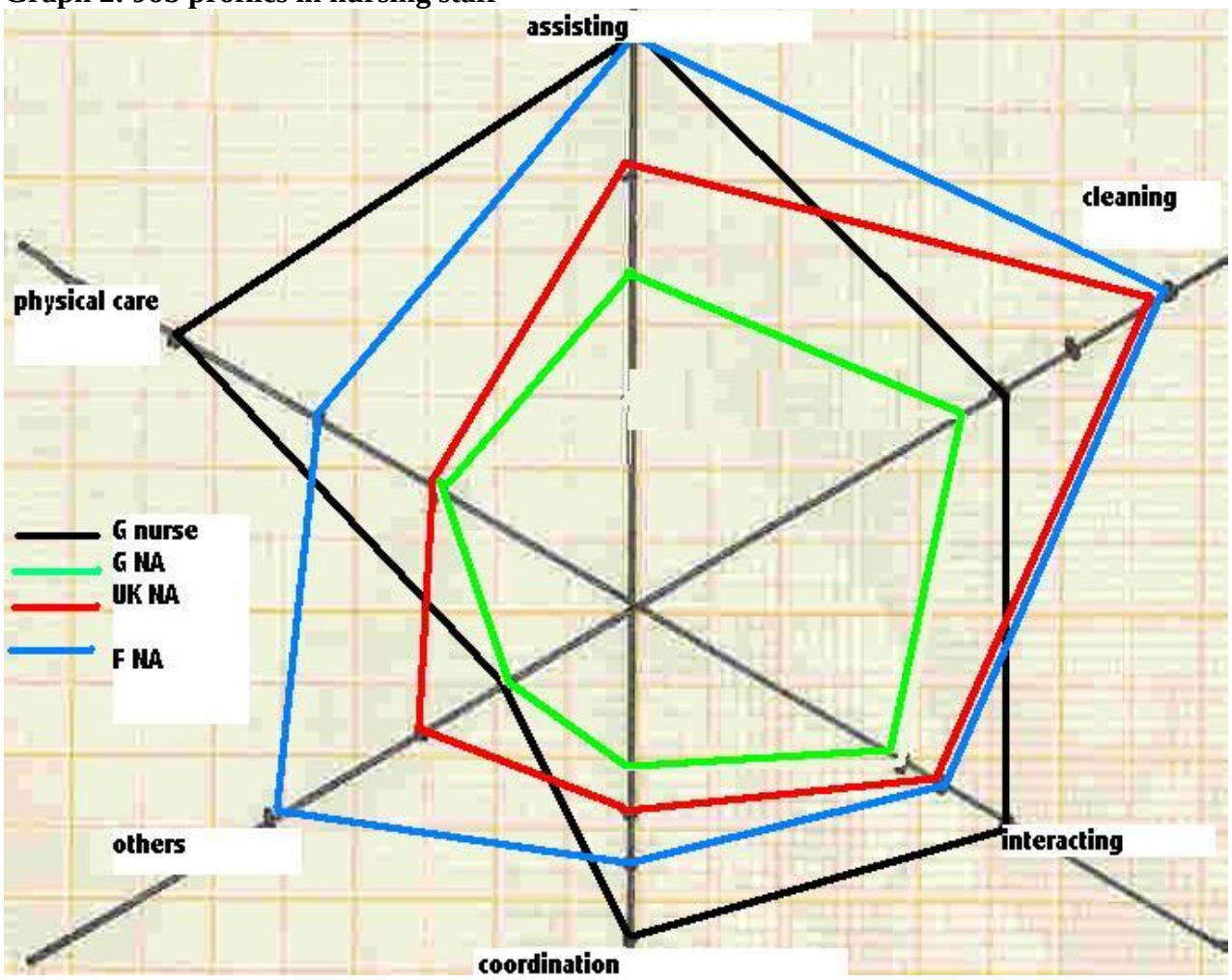
Based on our cases studies (NA interviews), we can draw up the job content of a NA in the three countries (including the nurse in Germany, as the NA position is so unusual). In a first stage of the interviews, those interviewed filled in a table describing the daily or less common tasks of a NA; Then, we organized the table in six dimensions and ranked (empirically) the frequency of the tasks according to the answers. The six dimensions are:

- *assisting the patient* (toilets, transport, position in the bed, in the room, helping to eat…)
- *cleaning activities* (patient room, other rooms, patient proximity, washing dishes, making empty or occupied beds)
- *interacting* (with the patient, the family, responding to patient's buzzer)
- *coordination activities* (exchanging within the ward team, organizing the NA's work with others, reporting about the patient's condition, access to the medical file…)
- *physical care* (elementary health care, taking patient temperature, blood sample, helping to take medicaments…)
- *various tasks within the ward* (managing and distributing linen, distributing food trays…)

The German NA (unqualified in our cases studies) has the narrowest span of tasks on the six dimensions. This corresponds with the low skill level of NA and with the high level of nurses (with a lower qualification than in F and UK): the German nurse is doing partly what would be delegated to a NA in France or the UK. The UK NA or HCA role is more complex than the German one: more cleaning or other activities (which are more often outsourced in Germany), more assisting tasks (which are performed by nurses in Germany). The job profile is similar to the French one. The main differences (due to the higher level of qualification in France) are, on the one hand on the amount of physical medical tasks (the French NA is authorized to perform more medical care under the nurse's supervision), on the other hand on "other activities" (in the French cases, there is no nutritionist assistant, linen is managed at the ward level), and lastly fewer coordinating activities.

The German nurse role looks like an intermediate 'skilled position", which fits well with the typical profile of the qualifications and skill structure built up by the dual system: less cleaning activities than the nursing assistants in the other countries, less "other activities" which are delegated to other, unskilled workers, but more involvement in medical (technical) tasks, in assisting the patient, in coordination tasks.

Graph 2: Job profiles in nursing staff



To understand the German picture, one must take into account, on the one hand, the role of the trainee nurses and, on the other hand, the role of volunteers. The trainee nurses (who spend a lot of time on the wards) perform some tasks which would be devoted, in the other countries, to the NA. Also volunteers doing national service perform some tasks which will be usually carried out by the NA in the other countries.

The relationship with the other categories (porters, room cleaners....) is less regulated. It depends more on the hospital's choices and policies. In Germany, due to the more skilled and integrated position of the nurse, the unskilled tasks are, to a higher extent, split off and devoted to room cleaners and others, accompanied with a greater use of outsourcing of cleaning. This was also the case in the UK due, on the one hand, to a more strict occupational division of labour (porters, room cleaners) and, on the other hand to the PFI initiative, which made a distinction between "cure and care" occupations and "hotel services" occupations. In France, the position of the ASH (incorporating both room cleaner, housekeeper and other tasks) provides a good example of the ambiguous position of the NA. On the one hand, the unskilled ASH, when integrated in a ward's work complement could overlap with the NA, work in pairs with her, have a permanent relationship with patients and families. On the other hand, when confined to cleaning activities (outsourced or not) the role will be similar to a German cleaner, but with a better job position (as regards wages and mobility).

4. National systems of wage-setting: Upward and downward paths of coordination

Comparing the systems of wage-setting might reveal another cause for the differences in the skill mix, since a more or less coordinated approach opens up more or less space for hospital managers to exploit wage differences.
The difficulty of comparing systems of wage-setting for nurses and nurse assistants working in hospitals in France, Germany and the UK is that while the majority are employed in the public sector, a significant proportion also work in the for-profit and not-for-profit segments of the private sector. Cross-country comparison thus requires a contrasting of public sector pay systems, as well as assessment of differences in coordination with other wage agreements for nursing in the private sector. In France, public sector hospital workers are governed by the general framework for public sector civil servants while nurses in the private sector follow a separate model of collective bargaining similar to other sectors in the French private sector. Nevertheless, there is a degree of informal coordination between sectors with recent evidence of the public sector providing an upwards reference point. In Germany, a similar situation applies for public sector hospital nurses as in France with wages covered under an integrated national public sector framework. In the church owned non profits hospitals, the national collective agreement is also the rule. However, in the German private for profit hospitals sector agreements are diverging from the public sector with an erosion of the convention whereby private hospitals would adopt the public sector terms and conditions and instead evidence of public sector hospitals seeking to adapt to the downwards reference point of private. In the UK, public sector pay has traditionally been more fragmented than in France or Germany with a wide array of separate agreements for different occupational groups in different sub-sectors. However, the different agreements for occupations within the public hospital sector are now covered by a new integrated, national framework, which has even been extended to workers in private sector firms providing contracted hospital services. Public sector pay systems remain very fragmented, but less so. A far smaller share of UK nurses work in the private sector than in France or Germany, but here wages are determined by individual hospital chains.

Table 2 sets out the main characteristics of wage-setting arrangements in the three countries. The public sector constitutes the majority of hospital activity in each country. In France and Germany, private sector hospitals are split between non profit and for profit organisations, with the private for profit sector greatest in France (20% of all beds), although it is growing rapidly in Germany through acquisitions of privatised local authority hospitals.

Qualified and Assistant nurses are represented by a mix of trade unions and professional associations in the three countries. In France, all the 5 national unions are representing the nurses and nurse assistant. Moreover, in the public sector, some other specific unions are playing a role. Nurses are also organized within professional associations, and are now claiming for an order, following the model of the doctor's organization. In Germany, the major trade union representing nurses' collective interests is the important services union, Ver.di, and the professional association, representing both Qualified and Assistant nurses**,** is the DbfK (Deutscher Berufsverband für Pflegeberufe)**.** In 1998 the 'Deutsche Pflegerat' was founded, a council that coordinates the positions of 11 professional Associations (among which DbfK). In the UK, union representation is mainly with Unison, the largest public services union. The professional nursing association, the Royal College of Nurses, also accepts Assistant Nurses as members providing they have reached a training standard of National Vocational Qualification Level 3.

Terms and conditions for nurses in public sector hospitals are, for each country, more coordinated than in the private sector, yet the scope for collective bargaining and degree of integration within the public sector varies by country. France and Germany have a nationally integrated structure of public sector pay and conditions for hospital workers fall within this wider umbrella. In France, it is the government that sets pay by statute with the same pay scales (*grille de la fonction publique*) applying to all public sector workers (Guillotin and Meurs 1999, Meurs 1993). Within this General Statute for Civil Servants (article 4), the special statute for public hospitals, implemented

in 1986, reproduces the main provisions and governs all matters, such as recruitment, mobility, pay, premia, and leave, as applied to hospital employees. Nevertheless, there is scope for some interplay between national statute and proposals arising from a form of collective bargaining between the state, the Federation of public hospitals and unions. In particular, during the early 2000s, industrial action in public hospitals led to many 'common protocols' that were subsequently included in the statute for civil servants. To a degree, therefore, this relaxes the centralised, institutional obstacles hospital authorities face in seeking to implement specific solutions to employment challenges.

Wage-setting for public sector hospitals in Germany is also integrated within a national framework for public sector pay, although recent trends suggest a loosening of linkages. Pay for nurses is traditionally set as part of an integrated settlement for the entire public sector (Meurs 1993). Along with other non-manual occupations without *Beamte* status (defined as Angestellte), nurses' pay was negotiated through collective bargaining by the 'BAT' agreement (Bundesangestelltentarifvertrag). Since one year, a new collective agreement has replaced both BAT and BMT (the former c.a. for the manual occupations); the new collective agreement (TVÖD) includes both employee groups, but not the Beamte). While public hospital authorities enjoy limited ability to withdraw from the collective agreement, they have in recent years pursued other efforts to 'bypass' it. Practices include the outsourcing of activities and establishing external companies to provide various business services; evidence of such practices is demonstrated by the reduction in the number of cleaners employed by public sector hospitals by one third between 1991 and 2002. Moreover, as in many sectors, public hospital authorities have the freedom to negotiate 'opening clauses' at a regional level on working time arrangements.

The UK system for public sector pay is by comparison very fragmented, and involves a range of forms of determination such as independent pay review bodies, pay-indexing arrangements and collective bargaining. Even within the one area of healthcare there were, until 2005, 10 separate arrangements for collective bargaining for different occupational groups (under the Whitley system) and separate arrangements for doctors and for nurses for whom pay was set through the process of independent pay review bodies (Seifert 1992). However, a new, more integrated system of wage-setting ('Agenda for Change') has replaced this with three nationally determined pay spines and, for the first time, harmonises terms and conditions across manual and non manual groups of workers (DoH 2004). The pay spine for doctors and dentists is rather separate. But the second and third spines, for nurses and other health professionals and for all other non managerial workers, are directly linked through a coordinated approach to determining basic pay awards.

The extent to which the public hospital sector agreement is a pattern setter for the private sector differs. In particular, we see a strengthening in France and the UK and a reversal of roles in Germany. In France, the 2002 collective agreement in the private for profit hospital sector aims to move towards provision of terms and conditions as favourable as provided by the public sector agreement (partly under pressure from public authorities by tying this to access to a special fund for additional resources). It states, 'the parties intend to further improve the employees' work conditions, in the framework of a convergence of wage rates of public and private hospital employees'. And this is occurring in a context where the public sector framework continues to establish an upwards pressure on terms and conditions. Recently, for example, it eliminated the lowest wage category (benefiting hospital cleaners and nurse assistants). Also, in the UK, the new pay structure for public sector hospital workers provided a substantial boost to the minimum basic pay rate (a rise of 16% - from £4.76 in 2003-04 to £5.52 in 2004-05), as well as provisions for more rapid skill development and career progression. And in response to concerns of a two-tier workforce within private firms providing outsourced healthcare services, a new 'Two-Tier Code' entitles such workers to 'terms and conditions no less favourable than' the national collectively bargained pay structure for public sector hospital workers.

Trends in Germany are different. Until the early 1990s (under the 'cost recovery principle' of financing), private non-profit hospitals regularly adopted conditions of the national public sector

wage agreement. The two main agreements for church hospitals were AVR Diakonie and AVR Caritas. But recent years have seen an erosion of this informal institutional linkage. The change has been possible in part due to the greater autonomy of church hospital employers, which enables them to respond to new cost pressures along a 'third way' path of industrial relations. Because of a legal exemption for churches, instead of being governed by the works council constitution act (*Betriebsverfassungsgesetz*) they are governed by their own church laws that grant workers fewer co-determination rights. As a result, church-owned hospitals have reduced wage levels in collective agreements, with minimum entry level wages up to 25% lower than in the public hospital sector agreement (€7.62 and €9.56, respectively). Faced with diverging wage trends between agreements in the public and private sectors, ongoing privatisation of local authority hospitals and outsourcing of business services, unions representing public hospital workers signalled a willingness to accept a decrease in wage rates (for less experienced workers) in order to counteract further shedding of public sector jobs (Ver.di 2004). The new agreement (from October 2005) has lower entry wage rates for assistant and qualified nurses, but has maintained much of the scope for seniority-related pay increases. In practice, it means that a cleaner in a public sector hospital earns less than specified in the private sector agreement for the cleaning industry. The new agreement also defines a new 1286€ low wage group, that can be applied to cleaners, but it has to be negotiated at regional level, which occupation is 'at the risk of outsouring' and therefore can be paid a reduced wage (where 1,286 is the minimum) So far, this has been agreed in one region (Hessen).

Table 2. Systems of wage setting for Nurses in public and private sector hospitals in France, Germany and the UK

	France	***Germany***	***UK***
Public sector share of total healthcare spending (OECD data 2002)	76%	78%	83%
Sectoral mix of hospital beds	Public (66%) Private non profit (15%) Private for profit (20%) *(2001 data, no. of beds)*	Public (55%) Private non profit (37%) Private for profit (8%) *(2002 data, no. of bed-days)*	Information unavailable
Representative employee bodies:			
- Assistant Nurses	5 national trade unions plus others specific to the public sector	Major trade union - Ver.di; Major prof. association - DbfK (Deutscher Berufsverband für Pflegeberufe)	Prof. assoc'n - Royal College of Nursing (only with NVQ Level 3); Trade union - Unison
- Qualified Nurses	Same as above + professionnal associations	Same as above	Royal College of Nursing
Wage-setting by sector:			
Public hospitals	National agreement, integrated as part of national public sector pay framework (the General Statute of Civil Servants)	National agreement, integrated as part of national public sector pay framework; new opening clause for weekly working time negotiated at regional level for hospitals	One national pay settlement for all public hospital workers, but not coordinated with other parts of public sector
Private non profit hospitals	Separate national agreements following private sector model of collective bargaining	Separate agreements for church hospitals (eg. AVR Diakonie, AVR Caritas); traditional linkage to public sector framework now broken	n.a.
Private for profit hospitals	Separate national agreements following private sector model of collective bargaining	Fragmented; most agreements made at establishemt level (*Haustarifverträge*)	Fragmented; separate agreements for each company

Low pay among nurses

The different wage-setting institutions described above have some bearing on patterns of low pay among the nursing workforce in the three countries. Table 2 shows that low wage work is not an issue for qualified nurses in any of the countries (with the exception of a small number undertaking training in France). However, for assistant nurses while low pay does not figure in France, close to one in ten are low paid in Germany and close to one in five in the UK. Indeed, in the French public sector hospitals no low pay is registered at all among assistant nurses. When compared to the incidence of low pay for all occupations, the situation in France is exceptional with an incidence far lower than the national average of 11%, whereas the UK the incidence among assistant nurses is very close to the national average.

Table 3. Incidence of low pay for Assistant and Qualified Nurses

	France	*Germany*	*UK*
National data	2001 data, full-time employees	2003 data, full-time employees	2005 data, full- and part-time employees
Assistant nurse	0% (public sector) 2.4% (private for profit sector)	8.8%	19% (D1 = £5.88 D2 = £6.45)
Qualified nurse	1.7%*	n.a.	0% (D1=£9.43)
All occupations	11.6%	17,7 %	22% (D1 = £5.35 D2 = £6.21)

Notes: Germany: the low wage threshold is €1.736 (West) and € 1.309 (East) per month (two thirds of the median for all full-time employees). UK: the low wage threshold is £6.37 (two thirds of £9.56, the median for all employees including overtime pay). France: the low wage threshold is 5.32€ in 2001 (net wages)
France, Askenazy, Caroli, Gautié (2006) Germany: Bosch/Kalina (2006); UK: ASHE (2005).
* trainees – 0% without

A cautionary note on comparability of data is needed, given that they derive from separate national sources. Differences involve inclusion of part-time employees in the UK data, use of monthly earnings data in France, and disaggregation by public/private sectors in France. Nevertheless, the differences in incidence of low pay are large enough to suggest that the position of France deserves explanation. One reason might be that downward pressures on low wage work are more extensive in Germany and the UK than in France. The UK minimum wage in April 2005 (the period of earnings data) was far below the low wage threshold (£4.85 and £6.37, respectively) and the absence of a nationally legislated minimum in Germany means many workers are not protected by a wage floor. By contrast, in France the SMIC is only marginally below the low wage threshold (5.29€ and 5.58€, respectively in 2002), thus reducing considerably the overall incidence of low wage work.

A second reason is the direction of institutional change concerning public sector pay. In France, as we detailed above, the French public sector has been revitalised as a pattern setter for the private sector and has recently eliminated the lowest wage band in an explicit effort to improve terms and conditions for public sector workers. This contrasts with Germany where wage-setting arrangements have shifted from the public sector as pattern setter to the private sector playing this role, with the result that pay for all groups has shifted down for newly recruited workers. A further important change in Germany concerns the abolition of the rule in 1997, which stated that cost increases arising from collectively agreed wage increases were excluded from the budget cap. This has added to strong pressures on hospitals to reduce wage rates; hospitals have largely achieved

this within the highly centralised collective bargaining system. The incidence of low pay in the UK is similar to Germany, but it is likely that the next year's earnings data will demonstrate a reduction since the new more generous pay structure was only applied in practice after April 2005 when the earnings data were collected.

Pay differentials among nurses

Drawing on information in the public sector collective bargaining agreements, table 3 indicates wide differences in entry level wage rates for assistant and qualified nurses across the three countries. This varies from a differential of just 18% in Germany to 57% in the UK, with France in the middle at 40%. This fits with the pattern of skill-mix we explore below since it is the narrow differential in pay between these groups that partly explains the very low share of assistant nurses in Germany.

Table 4. Pay differentials among assistant and qualified nurses

	France	*Germany*	*UK*
Entry level pay for qualified nurse (NA = 100%)	139%	117.5% (NA without exam) 112.0% (NA with exam)	157.4%
Average pay for qualified nurse (NA = 100%)	Not available	Not available	166.7% (all full-time and part-time)
Pay scale (NA entry pay = 100)			
Assistant nurses	100-145 (band A) 103-152 (band B)	100-132 (without exam) 105-149 (with exam)	100-124 115-138 (post for NVQ level 3)*
Qualified nurses	139-245 162-290 (anaesthetist)	117-161 (entry level) 153-168 (surgical nurse)	157-204 (entry level) 188-255 (specialist/ team leader) 223-299 (team manager)

Notes: Germany: pay scale details refer to the new collective bargaining agreement; UK: *a further higher level post (Assistant Nurse Practitioner) is possible for assistant nurses but this is not shown here. France : public sector
Source: Appendix table 1.

Despite these differences in starting rates, data on overall pay-scales show a remarkable degree of similarity in prospects for pay progress for assistant nurses. In all three countries maximum pay rates specified in collective bargaining agreements extend to between 138% and 150% of the entry wage for those progressing into posts requiring some form of accredited training.

All three country public sector agreements provide for seniority-related increases in basic pay rates. However, these are far more generous in France compared to the UK. In the UK an untrained assistant nurse will receive up to eight pay increments and a trained assistant nurse seven. In France, as is common in all collective bargaining agreements, seniority-related progression plays a far stronger role and provides for 28 years of increments for assistant nurses.

5. Mobility patterns : Job ladders to higher wage positions

UK

As noted earlier, there are no formal entry requirements for the position of Assistant Nurse. However, inked with the new pay bands (Agenda for Change) and the Knowledge and Skills Framework, the Department of Health has introduced the concept of a 'skills escalator' approach to staff development in the NHS, described in the policy document 'Working Together, Learning

Together' (Department of Health, 2001):

> We want to open up opportunities for people … at relatively low skill levels to progress their skills through investment in their training and development to professional levels and beyond, by moving up a 'skills escalator'.

The following table, from the same document, illustrates how this approach applies to different categories of staff:

Table 5 The Skills Escalator Approach

CATEGORY	MEANS OF CAREER PROGRESSION
Socially excluded individuals	6 month employment orientation programmes
The unemployed	6 month placements in 'starter'jobs
Jobs/roles requiring fewer skills and less experience	NVQs, Learning Accounts, appraisal, PDP
Skilled roles	NVQs or equivalent
Qualified professional roles	Appraisal and PDP to support career progression
More advanced skills and roles	As above, role development encouraged in line with service priorities/personal career choices
'Consultant' roles	Flexible 'portfolio careers' informed by robust appraisal, career and PDP

NVQ – National Vocational Qualification
PDP – Personal Development Plan
Source: Department of Health (2001) 'Working Together, Learning Together', Department of Health, London.

This approach encourages staff to renew and extend their knowledge and skills constantly through lifelong learning. The metaphor is used to illustrate how, in theory, an employee could move all the way up the escalator, from a cleaner or porter to a consultant or chief executive, although in practice there will be a variety of step-on and step-off points. It is hoped that this will not only enhance the career prospects of existing employees, but will enable NHS Trusts, as large employers, to engage with local communities in attracting a wider range of people to join the NHS, tackling problems of unemployment and social exclusion. It is also hoped that this approach will result in positive outcomes for patients through service improvements and a different skills mix, where roles, work and responsibilities are delegated down the escalator, where appropriate (Department of Health, 2002). In theory the Skills Escalator should help Nurse Assistants who wish to progress to move up the career ladder by moving to Band 3 or Band 4 positions, taking on extra clinical skills as 'roles and workload pass down where appropriate, giving greater satisfaction and generating efficiency gains' (Department of Health, 2002).

Examples of higher level opportunities available to Nurse Assistants include Band 3 posts for which NVQ Level 3 skills are required, including the new post of Junior Doctor's Assistant. These are nurse assistants who are on-call and trained to take some of the workload from junior doctors by carrying out routine procedures such as cannulation and phlebotomy. Some hospitals have also piloted the Assistant Practitioner role, a Band 4 position. Again these are nurse assistants with an NVQ Level 3 and two-year Foundation Degree who are trained to offer a higher level of support, by carrying out procedures such as venepuncture, ECG recording, or may go into therapy roles. By taking on these tasks previously performed by doctors or registered nurses these new roles provide an example of both career progression and labour substitution resulting in the 'efficiency gains' mentioned above. For Nurse Assistants the job ladder (or skills escalator) effectively ends with the Assistant Practitioner role. Further career progression would mean undergoing full qualified nurse training for an NA with the necessary experience and an NVQ3 qualification. This may not be

possible for practical or financial reasons. The best option for those NAs who wish to follow this route is to secure one of the nurse training secondments on 80 percent?? of salary that all hospitals offer annually. However these are limited in number (10 to 20 for each hospital per annum??) and always oversubscribed. After three to four years of training the qualified nurse starts on Band 5 and the expectation is that s/he will progress quickly to the next level and beyond.

France

Unlike in the UK, where no formal pre-entry qualifications for a Nurse Assistant post are required, in France admission to an NA training course requires specific educational qualifications, and/or a pre-entry examination, and training is carried out in vocational training schools linked with hospitals in either the public or private sector (see above). Although in some hospitals, a very small number of unqualified NAs are still employed, NAs are now only recruited once they have completed their training at an NA school and passed the final examination.

In France there are no intermediate positions between that of NA and the qualified nurse, but it is possible for NAs to prepare for the admission examination to nursing schools and this, as in the UK, is the main path to professional advancement beyond Nurse Assistant level. This is usually done with the support of the hospital (public or private) with help in preparation for the entrance examination and financial assistance. However, progression from NA to qualified nurse happens only very infrequently. One reason for this is that only few NAs apply for the nursing diploma because they may have been out of the education system for a number of years. The main reason, however, is because a reduction in support for this training has been necessary due to financial constraints, with the result that the number of nurse assistant courses financed by hospitals has dropped sharply. Pressures on training budgets mean that hospitals have to allocate resources to other priorities. The current shortage of specialised nurses and managers has necessitated that a large part of the training budget be allocated to training courses for qualified nurses at the expense of the NA.

Germany

The situation in Germany differs from that in both the UK and France. In some hospitals the employment of the Nurse Assistant ‘with exam’ (the one-year state qualification) is being phased out and the numbers of Nurse Assistants ‘without exam’ are relatively small. This indicates a growing ‘professionalisation’ of nursing, where even the basic patient-related care is carried out by qualified nurses.

As a consequence of the disappearance of the 'second portal', i.e. the nurse assistant with exam, the skill gap between nurses and lower qualified staff in nursing has widened. Whereas nursing assistants with exam could apply for a shorter vocational training as a nurse (2 years instead of 3 years), this is not the case for nursing assistants without exam. If they do not possess a 'Realschulabschluss' (= after 10 years of schooling) they first have to pass the exam as a nurse assistant. Even though the number of nursing assistants with exam is constantly decreasing and the case studies have revealed that hospitals do not recruit new nurse assistants with exam any longer, hospitals still offer vocational training courses as a nursing assistant; the number of courses offered has not decreased to the same extent as the number of nursing assistants employed.

There are two main obstacles that make it difficult for nursing assistants to enter a vocational training for nurses: Firstly, there is no specific financial assistance available, nurses in training earn a relatively low salary (between € 695 per month (East)/ € 729 (West) in the first year and € 845 / 885€ in the third year (West-Germany). As the training courses are mostly offered as full-time (although a part-time training stretching over 5 years is allowed by the law), nurses in training therefore have to rely on their own resources or assistance from other family members. This underlines that the vocational training system is tailored especially for young school leavers who still live with their parents, and less suited for older employees with (or even without) their own

children. This is reinforced by a second obstacle: some schools have age limits and only admit pupils below the age of 35 or even 25.

Compared to other occupations career progression in nursing is also made more difficult by the fact that there is no possibility to pass an 'external' exam after 6 years of professional experience; the only way to become a nurse is to go through a 2 or 3 years full-time-training.

Table 6 Opportunities for Career Progression for Assistant Nurses

	UK	France	Germany
Entry Level qualifications	None required	Minimum BEP « carrières sanitaires et sociales » and/or Entry by class room exam. Plus NA training course	NA with exam: 'Hauptschulabschluss' (=after 9 years of education) Plus NA training course NA without exam??
Training/Qualifications offered	Induction and mandatory training NVQ2 (Care) expected NVQ3 available	Induction, short training courses (1 or 2 days a year)	Vocational training courses
Higher Level Posts available	Band 3 (Level 3) positions (e.g. Junior Doctor's Assistant Assistant Practitioner (Band 4)		
Further career opportunities	Limited number of secondments to qualified nurse training	Small numbers offered financial assistance with entry to qualified nurse training	Lack of financial assistance and upper age limits in nursing schools make it difficult for NAs to train as nurses

Conclusions

At first sight our cross-country comparison seems to confirm the assumption mentioned at the beginning that differences concerning the quantity and the profile of low skill occupations are less strongly linked to differences in the vocational training systems than is the case for medium and high-skilled occupations. Despite differences in entry requirements and the duration of formal training for nursing assistants which are most marked between France and the UK, the job profile of the nursing assistants, and also their overall share of the nursing staff are quite similar and very different from the situation in Germany. By contrast, even though the legal framework and vocational schools in Germany provide for a formal training of nursing assistants, this legislation and the corresponding infrastructure has lost its importance for labour division in hospitals since hospital managers increasingly fail to make strong use of it and instead opt for the recruitment of skilled nurses.

At second glance, however, it becomes obvious that the vocational training system is influential in another respect: The higher skill requirements and longer duration of training courses for *nurses* in both France and the UK seem to prepare the ground for the assumption of more medical tasks and this in turn triggers a delegation of more care tasks from nurses to nursing assistants. By contrast, in Germany the vocational training of nurses supports a strong hierarchical integration of tasks in the job profiles of nurses, including tasks that are devoted to nursing assistants in other countries.[3]

[3] But this delegation in Germany is also hampered by the traditionally low staffing levels among nursing staff which contribute to the conservation of the traditional labour division between doctors and nurses, given the refusal of

Secondly the vocational training of nurses acts as a provider of trainee nurses who spend more time on the wards than at nursing school and are also used as a substitute for nursing assistants. The vocational training systems therefore obviously impacts on the job profile of nursing assistants rather indirectly, i.e. via the occupational profile of the nurse, and less directly, i.e. via the entry requirements and training curricula of the vocational training of nursing assistants.

The system of wage setting can also contribute to partly explain the differences: In the British case the Agenda for Change allows for wide wage gaps between the occupations of nurse and nursing assistant, whereas in Germany the integrated character of wage settlement within the public sector coincides with only relatively small wage gaps which limits the possibility for hospital managers to exploit wage differences and has contributed to the decline of nursing assistants. On the other hand, the increasing difficulties in coordinating wage settlements between public and private hospitals, as well as with other less organised segments of the service sector (cleaning), has put the occupation of the nursing assistant under pressure from below, as German hospitals are more inclined to unbundle tasks in housekeeping and devote them to low paid occupations (cleaners) and outsource these occupations. This also seems to work at the detriment of a 'semi-skilled' position of a nursing assistant, as thereby tasks are moved outside the scope of activities that are performed by nursing assistants in other countries. In the UK and France, this is counterbalanced a) by minimum wage regulations and b) by recent revitalisation of the public sector as a pattern setter for the private sector. The French example on the other hand shows that a highly coordinated system of wage setting does not prevent high wage differences between the occupations; which might also be explained by the weaker influence of unions and professional associations on wage setting and the important role played by the state in this respect.

Hence, this allows us to come back to the classical and robust conclusions of the various schools dealing with international comparisons in the field of the labour market and work organization (the societal analysis – Maurice, Sellier, Silvestre, 1982 – the productive system approach – Wilkinson, 1983. In a similar industry (probably more similar than other industries), in an industry which is facing similar pressures (with different time schedule and intensity), the division of labour is very different in our three countries for the same “product”, in the same kinds of hospitals and departments. The within-country differences do not overshadow the between-country differences. Various institutions (the training system, the wage setting systems, but also the industry specific institutions such as the quality of the care regulations) must be taken into account and combined in order to understand why in Germany the position of the nursing assistant is disappearing, why it remains a rather strongly defined occupation in France and why, in the UK, there is a new development of this intermediate position, with an upskilling process.

But we would also like to draw the attention to a less 'classical' result: The dynamic analysis shows, on the one hand a rather stable picture in France and, on the other hand an unstable and reversed picture in Germany and the UK. In the former country the trend is towards a renewed central institutionalization, with stronger national rules, skilling process, upgraded wages. Nevertheless, this trend fits well with the overall UK model. Contrary to that, the trend in Germany hospitals is not in line with what has been considered as the core of the German model. On the one hand the high skill road seems to be preserved (as the nurses are a stable group). On the other hand, with the vanishing of a semi-skilled position of the nursing assistant the job opportunities for those remaining workers without initial vocational training are put under very strong pressures with outsourcing and deregulation processes at work. It looks like an equivalent of the French model, where a lot of housekeepers and some NA are under short term contract, outside of the core workforce and waiting for a permanent job. In both countries, the initial vocational training system produces a higher number of skilled (nurses) or semi-skilled (nursing assistants) employees, but the reverse side is that those without having acquired these skills within the initial vocational training system are confronted with more obstacles (and increasingly so in Germany) in access to

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doctors to delegate not only the tasks but also the necessary resources, i.e. additional nursing staff. Without the additional resources nurses are not willing to take on additional responsibility, due to the chronic understaffing.

employment and career progression than their counterparts in the British system whose boundaries are more permeable both at the lower end (entry requirements) as well as at the higher end (career progresssion).

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Appendix

Table 1. Pay rates and payscale for Assistant and Qualified Nurses

France

	Pay scale (no. of increments)	Minimum	Maximum
Nursing Assistant (band A)	28 years of pay progress	€1184	€1417
Nursing Assistant (band B)	28 years	€1278	€1722
Nurse (band A)	21 years	€1655	€2019
Nurse (band B)	14 years	€2019	€2725

Note : public hospitals, net monthly wages, without some premia, without child allowance. Moving from band A to band B according to seniority and personal evaluation. Usually when reaching a certain level within band A you can apply for Band B. Only a maximum % of the staff in Band B

Germany

	Pay scale (no. of increments)	Minimum	Maximum
Nursing assistant without exam (old c.a.)	9 increments (last increment after 16 years)	€ 21,764	€ 26,086
" " (new c.a.)	5 increments (last increment after 15 years)	€ 20,318	€ 26,845
Nursing assistant with exam (old c.a.)	8 increments (last increment after 16 years)	€ 22,696	€ 29,340
	5 increments (last increment after 15 years)	€ 21,311	€ 30,186
Nurse (entry level) (old c.a.)	8 increments (last increment after 16 years)	€ 24,797	€ 32,035
	5 increments (last increment after 15 years)	€ 23,865	€ 32,678
Nurse (specialized, e.g. Surgical nurse)	Not at hands, I will check out on monday		

Notes
data refer to public hospitals
** yearly basic wages (gross) - whithout children/family allowance – ca. € 100 for married employees without children, ca. € 200 for married and unmarried employees with 1 child; ca € 100 per additional child*
*** yearly basic wages (gross) – without performance based supplements, to be introduced in 2007 and will be increased step by step up to 7% of wage sum of hospital; details not yet fixed*

UK

	Pay scale (no. of increments)	Minimum	Maximum
Assistant Nurse	Band 2 (points 2-9)	£11,879	£14,739
Assistant Nurse (Higher level)	Band 3 (points 7-13)	£13,694	£16,389
Assistant Nurse Practitioner	Band 4 (points 12-18)	£16,004	£19,248
Nurse (entry level)	Band 5 (points 17-25)	£18,698	£24,198
Nurse (specialist/team leader)	Band 6 (points 26-31)	£22,328	£30,247
Nurse (team manager)	Band 7 (points 28-36)	£26,498	£35,527
Nurse Consultant	Band 8 (points 35-52)	£34,372	£71,494